



Medi-Cal Managed Care Division

state of california



Medi-Cal Managed Care External Quality Review Organization

Report of the
**2005 Annual Review
Alameda Alliance for Health**

Submitted by
**Delmarva Foundation
October 2005**

Table of Contents

| | |
|-----------------------------------|-----|
| Introduction..... | 1-2 |
| Methodology and Data Sources..... | 2 |
| Background on Health Plan..... | 2 |
| Quality At A Glance | 4 |
| Access At A Glance..... | 11 |
| Timeliness At A Glance..... | 14 |
| Overall Strengths..... | 16 |
| Recommendations..... | 17 |
| References..... | 18 |

2005 Annual Review: Alameda Alliance for Health

Introduction

The California Department of Health Services (DHS) is charged with the responsibility of evaluating the quality of care provided to Medi-Cal recipients enrolled in contracted Medi-Cal managed care plans. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DHS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 and federal EQRO regulations, Delmarva has conducted a comprehensive review of Alameda Alliance for Health to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality**, stated in the federal regulations as it pertains to external quality review, is defined as “the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge” (“Final Rule: External Quality Review”, 2003).
- **Access** (or accessibility) as defined by the National Committee for Quality Assurance (NCQA), is the “timeliness in which an organization member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care” (“Standards and Guidelines”, 2003).
- **Timeliness** as it relates to Utilization Management (UM) decisions is defined by NCQA as when “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care” (“Standards and Guidelines”, 2003). An additional definition of timeliness given in the National Health Care Quality Report “refers to obtaining needed care and minimizing unnecessary delays in getting that care” (“Envisioning the National Health Care”, 2001).

Although Delmarva's task is to assess how well Alameda Alliance for Health performs in the areas of quality, access, and timeliness, it is important to note the interdependence of quality, access and timeliness. Therefore a measure or attribute identified in one of the categories of quality, access or timeliness may also be noted under either of the two other areas.

Methodology and Data Sources

Delmarva utilized four sets of data to evaluate Alameda Alliance for Health's (AAH) performance. The data sets are as follows:

- 2004 Health Employer Data Information Set (HEDIS) is a nationally recognized set of performance measures developed by the National Committee for Quality Assurance (NCQA). These measures are used by health care purchasers to assess the quality and timeliness of care and service provision to members of managed care delivery systems.
- 2004 Consumer Assessment of Health Plan Satisfaction (CAHPS), Version 3.0H CAHPS is a nationally employed survey developed by NCQA. It is used to assess managed care members satisfaction with the quality, access and timeliness of care and services offered by managed care organizations. CAHPS offers a standardized methodology that allows potential managed care beneficiaries to compare health plans. This comparison is designed to help the potential beneficiary select a health plan that offers the quality and access to care compatible with their particular preferences.
- Summaries of plan-conducted Quality Improvement Projects (QIPs).
- Audit and Investigation (A&I) Medical Audits – conducted by the Audit and Investigation Division of DHS to assess compliance with contract requirements and State regulations.

Background on Alameda Alliance for Health

Alameda Alliance for Health (AAH) is a full service, not for profit health plan contracted in Alameda County as a local initiative (LI) plan. The Plan has been licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since September 19, 1995. As of July 2003, AAH's total Medi-Cal enrollment was 74,015 members.

During the HEDIS reporting year of 2004, Alameda Alliance for Health collected data related to the following clinical indicators as an assessment of quality:

- Childhood Immunizations.
- Breast Cancer Screening.
- Cervical Cancer Screening.
- Chlamydia Screening.
- Use of Appropriate Medications for People with Asthma.

To assess member satisfaction with care and services offered by Alameda Alliance for Health, the CAHPS survey, version 3.0 H was fielded among a random sample of health plan beneficiaries. The survey was administered to adults and parents of children for whom Alameda Alliance for Health provides insurance coverage. Within the sample of children selected is a subset population of children who are identified as having chronic care needs (CSHCN population). This population differentiation provides regulators and other interested parties an understanding regarding whether children with more needs experience differences in obtaining care and services compared to children within the Medi-Cal population.

With respect to the Quality Improvement Projects, AAH submitted the following for review:

- Asthma Collaborative.
- Immunization Collaborative.
- Diabetes Collaborative.

The health plan systems review for AAH reflects joint findings assessed by DHS and the Department of Managed Health Care (DMHC). This review covers activities performed by the health plan from October, 2000 through September, 2001 and was conducted October 22-26, 2001. This process includes document review, verification studies, and interviews with AAH staff.

These activities assess compliance in the following areas:

- Utilization Management.
- Continuity of Care.
- Availability and Accessibility.
- Member Rights.
- Quality Management.
- Administrative and Organizational Capacity.
- Credentialing.
- Facilities.
- Medical Records.

Delmarva also reviewed the results of a routine monitoring review conducted by the DHS Medi-Cal Managed Care Division, Plan Monitoring/Member Rights Branch. The focus of this review covers services provided from January-June, 2003, was to assess how well member grievances and prior authorizations are processed and monitored. Additionally, Delmarva evaluated the cultural and linguistic services offered by AAH, as well as its marketing practices.

Quality At A Glance

HEDIS®

The HEDIS areas assessed for clinical quality can be found on page three of this report. The table below shows the aggregate results obtained by AAH.

Table 1. 2004 HEDIS Quality Measure Results for Alameda Alliance for Health

| HEDIS Measure | 2004 AAH Rate | Medi Cal Managed Care Weighted Average | 2004 National Medicaid HEDIS Average |
|---|---------------|--|--------------------------------------|
| Childhood Immunization Status Combo 1 | 59.1% | 64.7% | 61.8% |
| Breast Cancer Screening | 57.6% | 53.1% | 55.8% |
| Cervical Cancer Screening | 65.0% | 60.8% | 63.8% |
| Chlamydia Screening in Women | 48.6% | 38.5% | 45.0% |
| Use of Appropriate Medications for People with Asthma | 65.3% | 61.0% | 64.2% |

Alameda Alliance for Health exceeded the Medi-Cal managed care average and National Medicaid HEDIS average for four HEDIS measures, which displays strength in regards to these areas of quality. Only one measure, "Childhood Immunization Status", fell below the comparison averages.

CAHPS® 3.0H

As can be expected, Medi-Cal enrollees' perceptions of the quality of care received are closely related to their satisfaction with providers and overall health care services. Therefore, the CAHPS survey also questioned parents of AAH enrollees regarding their satisfaction with care. Also surveyed was a subset of the AAH childhood population who have special health care needs (CSHCN). They are reflected by the CSHCN notation in the table. The non CSHCN reflects the parents' response for children in the AAH population not identified as having chronic care needs.

Table2. 2004 CAHPS Quality Measure Results for Alameda Alliance for Health

| CAHPS Measure | Population | 2004 AAH Rate | 2004 Medi Cal Average |
|------------------------------|------------|---------------|-----------------------|
| Getting Needed Care | Adult | 69% | 69% |
| | Child | 80% | 77% |
| | CSHCN | 79% | N/A |
| | Non-CSHCN | 81% | N/A |
| How Well Doctors Communicate | Adult | 48% | 51% |
| | Child | 59% | 52% |
| | CSHCN | 68% | N/A |
| | Non-CSHCN | 57% | N/A |

CAHPS data reveals that the perception of getting needed care is more favorable for the child population than for the adult population. The AAH child rate exceeded the Medi-Cal average 80% versus 77%). Also of note is that parents of children with chronic care conditions (CSHCN) report slightly less satisfaction with “Getting Needed Care” than their non-CSHCN peers. The finding of lower satisfaction with this group highlights the need for AAH’s practitioner networks to enhance its sensitivity to the needs of this more vulnerable population.

Review of data indicating members' perception of “How Well Doctors Communicate” demonstrates that AAH parents of children and CSHCN members perceive practitioner communication as favorable. The AAH adult rate for this measure fell below the Medi-Cal managed care average. However, the child rate exceeded the Medi-Cal average by several percentage points (59% versus 52%). The finding that parents of the CSHCN population have a higher rate of satisfaction with communication as parents of Medi-Cal children leads one to infer that practitioners differentiate in their communication style between the two groups. Because the chronic care children are likely to have more serious health issues, the need for good communication between practitioners and parents is paramount in this subset of the childhood population. Thus this finding attributes to the belief that the needs of CSHCN are being addressed adequately.

Quality Improvement Projects

In the area of Quality Improvement Projects (QIPs), AAH used the quality process of identifying a problem relevant to their population, setting a measurement goal, obtaining a baseline measurement and performing targeted interventions aimed at improving the performance. However, after the re-measurement periods, qualitative analyses often identified new barriers that impacted AAH’s success in achieving its targeted goal. Thus quality improvement is an ever evolving process that may not be actualized due to changes in the study environment from one measurement period to the next.

The quality improvement projects (QIP) performed by AAH can be found on page three of this report. The following section provides a synopsis of each QIP undertaken by AAH.

Reduction of Inpatient Admissions and Emergency Room Utilization by Pediatric Members with Asthma

Relevance:

- AAH had high rates of inpatient admissions and emergency room utilization by pediatric members with asthma.

Goals:

- Decrease the rate of inpatient admissions and emergency room utilization by pediatric members with asthma through use of appropriate medication including beta agonists.

Best Interventions:

- Asthma disease management program offered to pediatric members with an inpatient admission or emergency room visit.
- Education of pediatric members and their parents regarding asthma management.

Outcomes:

- AAH documented improvement in the overall use of appropriate asthma medication. The rate of beta agonists was compiled only for 2001. Rates were as follows:

| Appropriate Medications: | Beta Agonist: |
|--------------------------|---------------|
| 2001: 51.6% | 2001: 20% |
| 2002: 60.7% | |
| 2003: 64.6% | |

Attributes/Barriers to Outcomes:

- Barrier: MCO unable to contract with a home health agency to perform in-home assessments.
- Barrier: Planned pharmacy intervention was unsuccessful.
- Barrier: Inaccurate claims and encounter data.

Immunization Collaborative

Relevance:

- Recognition of the need for timely immunizations for children.

Goals:

- Continued improvement and focused activities to increase the immunization rate.

Best Interventions:

- Identified providers accounting for high volumes of childhood immunizations.
- Established working relationships with immunization registries.
- Established collaborative relationship with other MCOs.
- Distribution of immunization registry flyers to educate providers.

Outcomes: 2003 rates for immunizations:

- Combo 1 = 59.12%
- Combo 2 = 59.93%
- Previous year's rates were not provided.

Attributes/Barriers to Outcomes:

- Volume of children needing immunizations.
- Sending files to providers from the registry is technically difficult.
- Issues funding member mailings.

Diabetes Collaborative

Relevance:

- Recognition of the need for timely and appropriate tests for members with diabetes.

Goals:

- Attain a 10% improvement from the baseline rate for HbA1c, LDL-C and eye exam HEDIS diabetes measures.

Best Interventions:

- Created a diabetes data warehouse to collect claims and encounter data at least monthly.
- Developed a stratification system to sort diabetics by risk criteria.
- Provided PCPs with monthly reports of diabetic members.
- Performed phone outreach to members with diabetes determined to be at highest risk for complications.
- Distributed quarterly reminder cards to diabetics regarding the importance of PCP visits and tests.
- Increased diabetic health education to diabetic members.

Outcomes:

| HbA1c rate | LDL C rate | Eye exam rate |
|-------------|-------------|---------------|
| 2002: 70.91 | 2002: 54.7% | 2002: 39.3% |
| 2003: 71.60 | 2003: 64.7% | 2003: 17% |

Attributes/Barriers to Outcomes:

- Barrier: Change in study specifications for eye exams.
- Barrier: Members difficult to reach by mail and telephone.
- Barrier: Members speak multiple languages.

Table 3 represents the Qualitative Results of each QIP.

Table 3: Quality Improvement Project Performance Results- AAH

| QIP Activity | Indicator | Baseline | Re measurement | | |
|--|--|----------|----------------|-------|--------|
| | | | #1 | #2 | #3 |
| Reduction of Inpatient Admissions and Emergency Room | Increase the use of appropriate medications for AAH members with asthma. | 36.1% | 1. 51.6% | 60.7% | 64.6%% |
| Utilization by Pediatric Members with Asthma | Increase the use of beta agonist to treat asthma. | 20% | | | |
| Immunization Collaborative | HEDIS Combo 1 rate. | 59.1% | | | |
| | HEDIS Combo 2 rate. | 56.9% | | | |
| Diabetes Collaborative | HbA1c | 70.9% | 71.6% | | |
| | LDL-C | 54.7% | 64.7% | | |
| | Eye exam | 39.3% | 17% | | |

Audit and Investigation (A&I) Findings

Delmarva reviewed the results of the joint audit performed by DHS and the Department of Managed Health Care (DHMC). Within the audit and investigation component of the quality review, AAH was assessed specifically in the following areas:

Quality Management

- Program Operation
- Reporting Requirements

Member's Rights

- Member's Rights
- Informed Consent
- Grievance System

Continuity of Care

- Coordination of Care: Within the Network
- Coordination of Care: Outside the Network/Special Arrangements
- Coordination of Care: Local Health Department
- Coordination of Care Monitoring
- Initial Health Assessment
- Referral/Follow-Up Care

AAH was found to have opportunities for improvement related to the Plan's program operations, reporting requirements, informed consent procedures and the grievance systems. As well, opportunities for improvement were identified with coordination of care outside of the network and for special arrangements, monitoring of coordination of care efforts, initial health assessments and referral/follow-up care. Within six months, AAH addressed all identified deficiencies to the Department's satisfaction.

Summary of Quality

In summary, AAH Health Plan demonstrates a quality-focused approach in administering care and services to its members. The plan demonstrates an integrated approach to working with its members, practitioners, providers and the internal health plan departments to improve overall healthcare quality and services.

Access At A Glance

Access to care and services has historically been a challenge for Medi-Cal recipients enrolled in fee-for-service programs. One of the Medi-Cal Managed Care Division's (MMCD) goals is to adequately protect enrollee access to care. Access is an essential component of a quality-driven system of care. The findings in regard to access are displayed in the following sections.

HEDIS®

Looking at access from a HEDIS perspective, access and availability of care are addressed through the Prenatal and Postpartum Care HEDIS measure. Two rates are calculated for this measure, the timeliness of prenatal care and the completion of a postpartum check-up following delivery.

Table 4: 2004 HEDIS Access Measure Results for Alameda Alliance for Health

| HEDIS Measure | 2004 AAH Rate | Medi Cal Managed Care Weighted Average | 2004 National Medicaid HEDIS Average |
|--|---------------|--|--------------------------------------|
| Timeliness of Prenatal Care | 72.0% | 75.7% | 76.0% |
| Postpartum Check-up Following Delivery | 55.7% | 55.7% | 55.2% |

AAH scored above the Medi-Cal managed care average and the National Medicaid HEDIS average for the "Timeliness of Care" rate and either at or below the comparison averages for the "Postpartum Check-up Following Delivery" rate. Postpartum care is impacted by the health plan's access to correct demographic information for outreach to postpartum members. These results regarding access appear to be strengths for AAH.

CAHPS®

Member satisfaction scores related to access to services are addressed in a composite rating calculated as part of the CAHPS survey. This composite rating for "Getting Care Quickly" is used as a proxy measure for access and availability.

Table 5. 2004 CAHPS Access Measure Results for Alameda Alliance for Health

| CAHPS Measure | Population | 2004 AAH Rate | Medi Cal Managed Care Average |
|----------------------|------------|---------------|-------------------------------|
| Getting Care Quickly | Adult | 34% | 35% |
| | Child | 44% | 38% |
| | CSHCN | 47% | N/A |
| | Non-CSHCN | 42% | N/A |

Findings from 2004 indicate that AAH exceeded the Medi-Cal managed care average for the child rate in this measure. The adult rate fell below the comparison average by only one percentage point (34% versus 35%). However, it is important to note that children with chronic care needs (CSHCN) and the Medi-Cal children's population have different rates of satisfaction with access. When considered with the CAHPS quality assessment for getting care when needed, one can deduce that the complex care population is slightly less satisfied with their ability to obtain routine care however, when they perceive a more urgent need, they are able obtain care more compatible with their expectations.

Quality Improvement Projects

Alameda Alliance for Health quality improvement projects all focused upon improvement of clinical indicators. However, within the barrier analyses for each project, potential access barriers were frequently identified. The identification of these access barriers is followed by interventions targeted to improve access. Several of the QIP activities identified access as a barrier in the performance of the qualitative analysis of their projects. Actions were then taken to ameliorate or when possible, eliminate the identified access barrier. For examples of access barriers identified, refer to the quality section discussion of QIP activities: attributes/barriers to outcomes.

Audit and Investigation (A&I) Findings

Delmarva reviewed the results of the joint audit performed by DHS and DMHC. This audit covered health plan activity from 2001 to 2002 and encompassed a compliance review considering the following requirements which represent proxy measures for access:

Member's Rights

- Cultural and Linguistic Services.
- Primary Care Physician

Availability and Access

- Access to Medical Care.
- Access to Emergency Services.

Access to Pharmaceutical Services.

- Access to Specific Services.
- Access to Providers.

After completion of the review, DHS/DMHC, identified opportunities in the area of access to medical care, emergency, pharmaceutical and specific services. As well, deficiencies were identified by DHS/DMHC related to access to providers and cultural and linguistic services for threshold languages. To address these opportunities, DHS/DMHC conducted active oversight of AAH's corrective action process. AAH effectively implemented recommendations related to Access Review Requirements and corrected each identified opportunity within six months of the final report findings.

Summary of Access

Overall, access is an area where continued work towards improvement occurs. Parents of Medi-Cal enrollees perceive that access to care quickly is better with AAH compared to Medi-Cal parents on average. Combining all the data sources used to assess access, AAH has addressed the areas noted in the DHS/DMHC audit where the health plan displayed vulnerability and corrected the identified issues in order to comply with the access standards required by DHS/DMHC.

Timeliness At A Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medi-Cal managed care enrollees. Equally important is the timely delivery of those services. The findings related to timeliness are revealed in the sections to follow.

HEDIS®

Timeliness of care is assessed using the results of the HEDIS Adolescent Well Care Visits and Well Child Visits in the First 15 Months of Life, as well as the DHS developed Blood Lead Level Testing measure. All Medi-Cal managed care plans were required to submit these measures.

Table 6: 2004 HEDIS Timeliness Measure Results for Alameda Alliance for Health

| HEDIS Measure | 2004 AAH Rate | Medi Cal Managed Care Weighted Average | 2004 National Medicaid HEDIS Average |
|---|---------------|--|--------------------------------------|
| Well Child Visits in the First 15 Months of Life - 6 or more visits | 61.1% | 48.7% | 45.3% |
| Adolescent Well-Care Visits | 37.5% | 33.9% | 37.4% |
| Follow-Up Rate for Children with elevated BLL at 24 Months | 50.0% | 53.7% | N/A |
| Follow-Up Rate for Children with elevated BLL at 27 Months | 0.0% | 33.1% | N/A |

The “Well Child Visits in the First 15 Months of Life or 6 or more visits” and ‘Adolescent Well-Care” measures exceeded both the Medi-Cal managed care average and the National Medicaid HEDIS average. When looking at this data compared to the HEDIS childhood immunization results for AAH, it is of interest that the immunization rate is found to be low, yet the “Well Child Visits in the First 15 Months of Life or 6 or more visits” rate is high. One might presume that since the well child rate was high, that the immunization rate would be high as well, however this is not the case. This finding may indicate missed opportunities for immunizations. AAH needs to review these results more intensively to address if opportunities to immunize are being missed. Overall, however, these results display strengths in the area of timeliness pertaining to timeliness measures.

CAHPS®

Member satisfaction scores related to timeliness of services are addressed in two composite ratings calculated as part of the CAHPS survey: Courteous and Helpful Office Staff and Health Plan's Customer Service.

Table 7. 2004 CAHPS Timeliness Measure Results for Alameda Alliance for Health

| CAHPS Measure | Population | 2004 AAH Rate | 2004 Medi Cal Average |
|------------------------------------|------------|---------------|-----------------------|
| Courteous and Helpful Office Staff | Adult | 46% | 54% |
| | Child | 60% | 53% |
| | CSHCN | 68% | N/A |
| | Non-CSHCN | 56% | N/A |
| Health Plan's Customer Service | Adult | 66% | 70% |
| | Child | 72% | 72% |
| | CSHCN | 73% | N/A |
| | Non-CSHCN | 77% | N/A |

Members' perception of courteous and helpful office staff generally impacts utilization of services. The AAH adult rate for this measure reveals that office staff is less helpful when compared to the general Medi-Cal population. The child rate was found to be higher to the Medi-Cal average (60% versus 53%). The adult rate fell below the Medi-Cal average by several percentage points (46% versus 54%). However, the Alameda Alliance for Health CSHCN rate for this measure exceeded the adult and child rates. It is noteworthy that parents of children with chronic care needs find office staff more courteous and helpful than their Medi-Cal peers. This is important as this population often requires more guidance from office staff in order to avoid crisis care management. AAH adult members generally find health plan customer services staff less helpful than the child and CSHCN population. The CSHCN population is likely to require more information related to direct medical care. This information is likely to be better provided by the medical office staff.

Quality Improvement Projects

Timeliness was a focal area of attention in most of the QIPs. Member-focused efforts consisted of assuring that members were reminded of preventive services prior to the age range when the services are due. AAH used a variety of mechanisms to address timeliness, including sending reminders, disseminating preventive health guidelines to members and clinicians and providing evidence-based literature to the practitioner network. Practitioner barriers related to timeliness issues focus upon the lack of timely provision of care or services due to missed opportunities.

Issues related to timeliness of services may very likely be impacted by access. AAH acknowledged the relationship between timeliness and access within the barrier analysis of the QIP where access was often

identified as a barrier. If care or service cannot be obtained, timely provision of the needed service is unlikely. The interdependence of access and timeliness is further illustrated in QIP studies that are HEDIS-related and focus upon services received (access) as well as the timeframe in which the service was provided (timeliness).

Audit and Investigation (A&I) Findings

Delmarva's review of DHS/DMHC's plan survey activity from 2001-2002 evidenced that the following review requirements were monitored and reflect adequate proxy measures for timeliness:

- Utilization Management
 - Prior Authorization Review Requirements.
 - Prior Authorization Appeal Process.

DHS/DMHC assessed timeliness review requirements and made recommendations for improvement related to prior authorization review requirements. AAH effectively addressed issues identified in the Utilization Management Process and corrected identified deficiencies within six months to the Department's satisfaction.

Summary for Timeliness

Timeliness barriers are often identified as access issues. AAH demonstrates strength in timeliness as a component of quality care in the area of well child care visits as well as adolescent well care visits. AAH scored above the Medi-Cal average for both of these measures. AAH also addressed timeliness in many of the QIPs. Each HEDIS quality measure combines the receipt of the service with the timeframe for provision of the service. Both elements must be met to achieve compliance. Since most of the QIPs focus upon HEDIS-related topics and methodology, AAH demonstrates an awareness of the importance of timeliness in the provision of overall quality care and service.

Overall Strengths

Quality:

- Commitment of AAH management staff towards quality improvement as evidenced by the rapid response and resolution of the deficiencies cited during the audit and investigation reviews.
- Improvement in the provision of care to members with diabetes in the areas of hemoglobin A1c as well as LDL-C screening.
- General precise documentation within the QIP that defines the problem under study, indicator measures and the tri-focal approach to interventions taken to attain improvement followed by reassessment for improvement.

Access:

- AAH parents of CSHCN enrollees express greater satisfaction with access to “get care quickly” than the parents of Medi-Cal enrollees on average. This is particularly important for chronic care populations as the inability to receive care quickly often leads to inappropriate hospitalization.
- AAH parents of Medi-Cal children are generally more satisfied with the ability to “get care quickly” than Medi-Cal parents on average.

Timeliness:

- AAH exceeded both the Medi-Cal average as well as the National Medicaid average for 15 month childhood visits as well as adolescent well care rates.
- AAH’s recognition of the interdependence of access and timeliness for improvement of care and/or services to be realized.

Recommendations

- Conduct follow-up assessments of the perception of the intended audience receiving educational endeavors. Follow-up with practitioners and/or members to determine if educational materials were effective toward producing the desired behavior or outcome.
- Perform periodic monitoring within areas identified in the medical audit as deficient to make certain that the actions undertaken to correct the issues remain effective.
- Perform further investigation of low satisfaction areas identified by CAHPS.
- Assess the disparities in quality of care and/or services among differing ethnic populations within the managed care membership. Understanding this phenomenon will enable focused resource allocation.
- Perform interventions such as random sample surveys to understand if members’ perceptions of their ability to care when needed has an impact upon the actual receipt of timely care or service.
- Coordinate activities between quality and provider relations staff to enhance the likelihood of compliance with timeliness standards.
- Find alternative mechanisms to obtain accurate member demographic information if outreach mailings and phone calls will remain a major strategy of outreach to members.

Recommendations that have been implemented independent of the EQRO feedback should be viewed as information only and be continually monitored by the health plan for assessment of improvement to be included in next year’s plan specific report.

References:

California Department of Health Care Services, Medi-Cal Program. (2003).

*External Quality Review Organization Contract- Delmarva Foundation
for Medical Care, Inc., Exhibit A, Attachment I- Detailed Scope of Work, 03-75611.*

California Department of Health Services, Medical Care Statistics Section. (2004, August). *Interim Managed Care Annual Statistical Report*. Retrieved

November 18, 2004, from California Department of Health Services website:

www.dhs.ca.gov/mcss/PublishedReports/annual/managed_care/mcannual04/04report.htm

California Department of Health Care Services, Medi-Cal Program. (2004, December). *Medical Services Provider Manual, Part 1- Medi-Cal Program*

and Eligibility, Medi-Cal Program Description. Retrieved November 1, 2004, from California Department of Health Services website:

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/00medi-cal_z00.doc

Centers for Medicare and Medicaid Services (CMS). (2002, June). *Final Rule: Medicaid*

Managed Care; 42 CFR Part 400, et.al. Subpart D-

Quality Assessment and Performance Improvement. Retrieved December 9, 2004, from CMS website:

<http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf>

Centers for Medicare and Medicaid Services (CMS). (2003, January). *Final Rule: External Quality Review of Managed Care Organizations and*

Prepaid Inpatient Health Plans; 42 CFR Part 438.300 et.al. Retrieved November 1, 2004 from CMS website:

<http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf>

Institute of Medicine (IOM), Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report*. Retrieved February 24, 2005, from the National Academies Press website:

<http://www.nap.edu/html/envisioning/ch2.htm>

National Committee for Quality Assurance (NCQA). (2003). *Standards and Guidelines for the Accreditation of MCOs*.